ImpAct

- *sharing experience*
- *defining good practice*
- *improving service delivery*
- *supporting learning in the NHS*

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November 2000 Volume 2 Issue 6

NHS Learning Network

Dead projects society

One of ***the*** main challenges for people who make a difference is to turn the new into part of the routine of mainstream activity. New projects get extra resources and are more exciting than the routine. There is also ownership that may not be there for everyday tasks. Making the jump from project to mainstream is difficult. Without it there is a danger that as special funding comes to an end people lose interest and enthusiasm falls away. The work becomes just another dead project: the effort has achieved short-term improvements but practice and services have lapsed back to where they were before.

Conscious of these dangers, we thought it would be good to look again at one of the initiatives we reported in ***ImpAct*** issue 1**.** Is it still going or has become a dead project? Therapy assistants continue to thrive at Bradford. Indeed we report on a similar initiative in the new Stroke Unit at Bradford.

There are two other case studies in this issue. The first looks at ways to meet the needs of *special children*: a real problem if the plans can't be made to stick. The other one tackles prescribing in primary care. It shows how a *practice pharmacist* can make an impact. We also report on Beacon services and tell you where to find them and how to use them, plus we have an update on more useful information appearing on the ***Bandolier/ImpAct*** Internet site.

In the July issue we reported on efforts to evaluate ***ImpAct***. It's also good to get unsolicited comments like: *"..the centre-spread from* ***ImpAct*** *on bottom lines for success is pinned to my office wall - good common sense stuff and it works."*

We often ask ourselves whether we are finding stories that you want to read. We think we are covering the right things, but if there are topics you would like us to cover please let us know. Help us find local success stories that can make the NHS better and make working in it better.

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WORKING THROUGH THE MAZE

Ensuring an integrated approach to the care of special children in Sutton, Surrey

Why was the initiative launched?

Although his special needs were identified when he was three years old, a young boy with learning difficulties subsequently got lost in the maze of local systems. His mother was frustrated by the lack of progress over the following three years and her failure to get the support he needed. She was thwarted at every turn: he was not getting anywhere. She turned for help to her GP in Sutton.

It was a familiar problem to many GPs. Effective treatments were known and available, but local services simply could not to deliver. Something had to be done. Plans for an outreach paediatric clinic being taken forward by the local hospital seemed to offer an ideal opportunity to look for practical ways to improve the situation. The practice had been part of a total purchasing project and was starting work as a first wave PMS pilot. The greater flexibility these arrangements offered also seemed promising.

Where did they start?

The first step was to find out what had gone wrong. A comprehensive assessment had been undertaken when the boy was three years old. His needs were clear and known to those involved. But suitable care and treatment had simply not been delivered.

Problems arose as the child moved through the education service from pre-school to junior school. Each agency had different criteria for triggering the *statementing* process and each in turn was supported by different parts of the NHS. The results of clinical assessments for therapies were not passed on from one service to another so the child was continually waiting! Local services would not accept assessments undertaken by others. All the good work in his pre-school years had been lost.

Location was a big contributory factor. The practice bridged three health authorities, three local authorities and two regions. A walk of 100 yards from the railway station to the practice crossed the patch of eight public sector organisations and a multitude of voluntary organisations. All had waiting lists and different criteria for access to services. The solution had to cut through this maze of local systems.

Finding a systematic way of working

The practice set up a multi-disciplinary team to design a system that would ensure that childrens needs were met. The team consisted of Dr Paula Sneath, Consultant Community Paediatrician from Epsom and St Helier NHS Trust (who was planning the outreach clinic), Sue Lynch, a Health Visitor attached to the practice and working for Croydon Community Trust, and Dr Anne Hollings, a GP.

East Surrey Health Authority gave the team a small budget to fund blocking problems faced by children with special needs. The health visitor put together a detailed picture of services available with their criteria and the working practices involved, and started to develop links with liaison staff in education services and schools. The team chose to focus at operational level, directly with other clinical staff, rather than look for strategic, policy solutions.

The team decided that the key to success would be a systematic way of working. The new clinic would provide the base for it. The starting point would be a thorough consultant-led assessment that would enable the team to agree a suitable management plan for individual children. The GP would take responsibility for medical follow-up and the health visitor would liaise with the family and local organisations to make sure that those involved in delivering elements of the plan knew what was required. Regular monitoring of progress coupled with prompt action when treatment drifted away from the plan would be essential.

Is the new system working?

Work started in earnest on the new approach in 1996 and the system continues to develop. Following a gradual build-up during 1997 the team is now managing care for about 15 children with special needs. A diary of patients, maintained by the health visitor, supports the monitoring process. The Consultant's secretary has proved to be a valuable co-opted member of the team. She is an important channel for communications for the practice. The health visitor takes the initiative to keep in touch with the children and provides updates for other the team members. Children don't need always to be attending clinics, and about a quarter of the children are managed in this way.

Keeping on track

If a care plan is interrupted or treatment diverges a range of actions has been developed. These include suitable letters from the paediatrician or GP, contacts by the health visitor with liaison staff in other agencies and occasionally an offer to meet any additional costs (such as the cost of a contribution to an assessment). In the event the offer of funds rather than payment has often been sufficient to open the door. For example a hold-up for one child arose because of problems in securing a therapy contribution to the assessment. An offer to cover the modest cost of the therapy contribution, some £43, was sufficient to get the case moving again!

A child with special needs:

Before**:**

He stood silent with his back against the wall. He looked like a normal 7 year-old boy except for the constant nervous twitching movements of his face and arms. He was struggling at school and receiving none of the support he needed.

After**:**

He has lost all his twitching, enjoys school and has kept up academically with his age group. He believes in himself again.

By creating a strong team and working on the needs of the child the team has created a system to deliver care during the school years for the children with special needs. No longer do GPs find the child with special needs a heart sink consultation because they know there is a way that they can help. The trust built up in the team has had an important impact on local services: GPs can now refer direct rather than through the Consultant. It has speeded up the process and eliminated irritating delays.

For the boy whose situation that prompted the work the first step was to catch up with the treatment that he had missed. The working group commissioned a period of intensive treatment from a local speech therapist over the school summer holiday. He is now doing well (see Box).

Tips for success

- √ Be persistent and don't take no for an answer.
- √ Remember offering small sums may open many doors, but the cash may not be needed.
- √ Look at the roles different people can offer to support the work: don't underestimate the contribution that can be offered by administrative and secretarial staff.
- √ Get to know your patch. It may take time to get to know local services but that time won't be wasted.
- √ Make team development a central objective. Teams that trust and work well together are much more effective.

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ImpAct bottom line

⇒ Seek operational solutions – don't let local policies get in the way

BETTER PRESCRIBING:
BETTER PRACTICE

Exploring the benefits of a pharmacist's role in primary care at Northgate Medical Centre, Walsall

Why was the initiative launched?

In the early stages of the development of GP fundholding at the Northgate practice it became clear that an important indicator of success would be how the practice handled prescribing. Could they manage this aspect of their practice effectively? The challenges were about the way the practice obtained and used advice and information about medicines. Creation of a practice formulary would be a key step.

The problems would be about time, a scarce commodity in primary care, and about expertise because GPs were not trained in the detail of prescribing policy-making and formulary development. Employing a pharmacist made sense. The opportunities presented by the introduction of fundholding offered an opportunity to do it. The Northgate practice with five GPs decided something had to be done.

Making it happen

One of the partners, Dr Denys Wells, approached the Good Hope Hospital, Sutton Coldfield, to second one of their pharmacists to the practice. The initial request was for some part-time help to set up a practice formulary. But there emerged a feeling that a practice-based pharmacist had more to offer than the limited task of setting up and maintaining the formulary.

Initial discussions encouraged those involved to think through the role a practice-based pharmacist could play. Clarity about the objectives of more rational and effective prescribing would be required. The practice agreed that the key criteria must ensure that recommended medicines were:

- Safe
- Effective: using medicines with good evidence
- Available
- Acceptable to patients with few side effects.
- Cost was an important factor but would flow from rather than dictate inclusion.

The practice-pharmacist role

Discussions about overall objectives formed the background for a business plan for the proposal. This described four distinct roles for the practice-based pharmacist, ie:

1 *Administrative*: centred on the creation and maintenance of the formulary. Other tasks would include the management of repeat prescribing and ensuring that medication records were kept up to date. Better use of PACT data, with analysis and discussion, would be possible.
2 *Clinical:* to help improve the quality of care to patients. The tasks would include providing information about drugs to general practitioners and counselling for patients. It would also include monitoring drug therapy and adverse reactions. Time would also be available for direct patient care at anti-coagulant and migraine clinics which would help save GPs' time!
3 *Interface:* to improve liaison with clinicians in secondary care. The aim would be to ensure continuity of care after discharge or treatment as outpatients.
4 *Research:* to help improve the quality of prescribing in the longer term, for example through involvement in research studies and medical audit.

The practice now knew what it wanted to achieve; the next step was to see if it could find the right person for the post. There were few doubts that the new post was a challenging role and would require someone who had:

- *Experience* in primary and secondary care and perhaps as a community pharmacist.
- *Knowledge* about the range of pharmaceutical products and sources of information about their effectiveness.
- *Authority* to stand up to and to persuade senior clinicians to change.
- *Teaching* skills to help doctors be better prescribers.
- *Team* approach and would fit into the local practice.

Local enquiries identified Marion Bradley, who was then working in the Pharmacy Department at Good Hope Hospital. She stared work with the practice in 1994.

What has been achieved?

The first task, creation of a practice formulary took about three months. PACT data and other information about effective medicines provided its basis. The aim was not to provide a narrow straight-jacket for partners but to provide a framework for better prescribing. The criteria proved to be helpful in assessing content. While some preferred medicines were included initially other oddities were excluded. The formulary is now well regarded and used. It is kept up to date. It is proving to be an important aspect of promoting evidence-based practice.

The post has many practical signs of success, with the practice-pharmacist a respected member of the team. Pharmaceutical care of patients has improved and time is being saved for both partners and practice staff. For example, the practice-pharmacist rather than GPs now runs anti-coagulant and migraine clinics. Much of her time is spent answering enquiries from patients about medicines. The service has been particularly well received by patients, grateful comments from patients and carers include *"I'm very pleased with the speed and kind attention I now receive"* and *"I can call Marian if I'm worried about Mum".*

The practice–pharmacist also manages repeat prescribing. A recent initiative, in partnership with community pharmacists, to change to salbutamol CFC-free inhalers went well: a consequence of the good local working relationships. Arrangements have also been made to ensure more effective management of prescribing for patients in local nursing and residential homes with important changes being

achieved. The practice pharmacist provides a formidable contact for local representatives from pharmaceutical companies. Because of other pressures, it has not proven possible to devote significant time to the proposed research role although contributions have been made to a number of research studies, related to the use of statins and endoscopy.

One regret is that the practice did not from the outset set up baseline indicators to monitor and measure the improvements in prescribing ***quality*** they have been able to achieve. They have to use broader costings to see the overall effect. These are encouraging but there is a danger that their work is seen to be about saving money! Over the last four years prescribing costs have been consistently about 20% below health authority and national averages (Figure 1). Practice prescribing costs have grown by under 6% a year, compared with local and national growth rates of about 9%.

Tips for success

- √ Decide how you will measure progress and success. It's no use believing that this will be possible in retrospect.
- √ Find the right person. Make sure you know what you want and expect of them.
- √ Recognise the merit of effective multi-disciplinary team working. Learn to share tasks to match skills.
- √ Value time. Ensuring that the time of individual clinicians is used to the best effect is an important step to securing quality care.
- √ Don't expect overnight success. It takes time to set up new roles and relationships.

Next steps

The initiative has proven the value of reliable, on-site, prescribing advice in primary care. More effective prescribing and better management of resources can be achieved. But the end of GP fundholding signalled the end of the scheme. Most practice pharmacists have since taken up posts as PCG pharmaceutical advisers. Marian Bradley now tries to combine the practice-based role (working with three practices) with that at PCG level. The many demands do not however allow the previous detailed attention. The lessons from this initiative suggest that this type of support will be important at practice level as PCGs take on their commissioning role. But there are unanswered questions:

- What is the practical way of funding these posts?
- How can primary care groups manage resources locally to secure an optimum, effective, level of pharmaceutical input to local practices?
- Do choices have to be made between administrative and clinical roles. Where is most to be gained?
- Are there enough suitable skilled and experienced pharmacists to fulfil this role?

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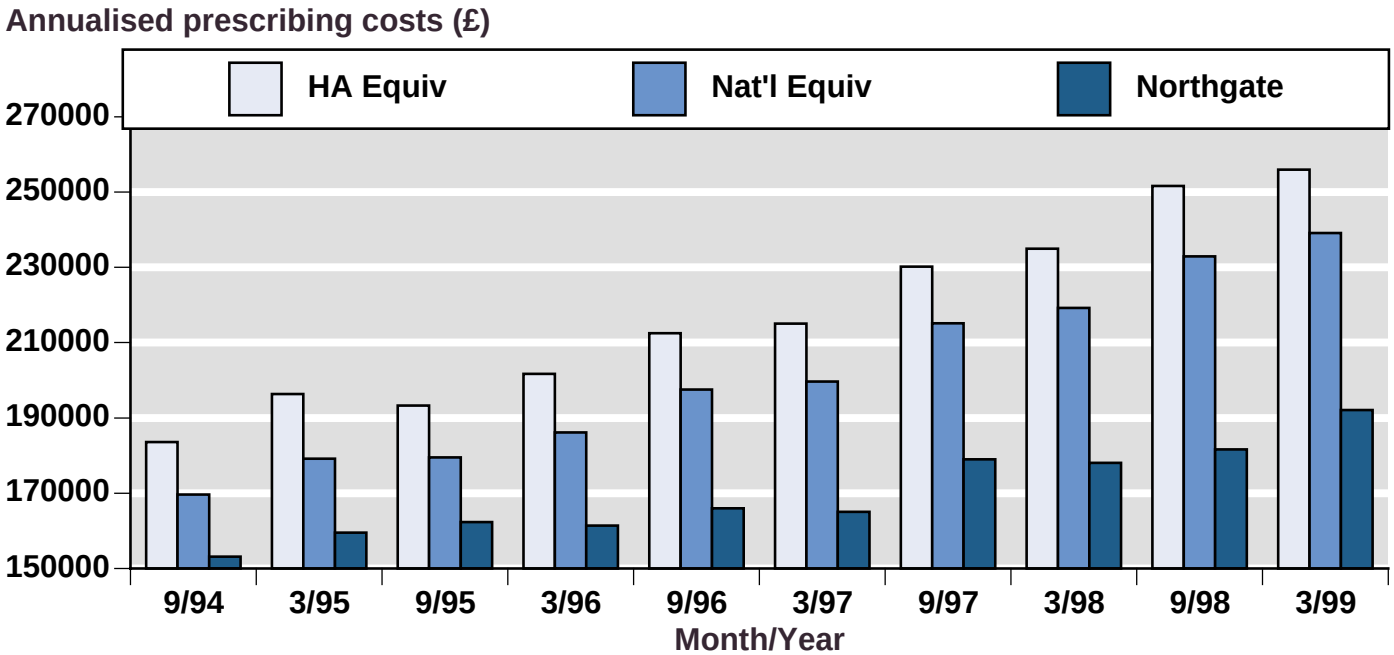
The following material is available:

Note about the practice pharmacist role
Articles and papers about the practice-pharmacist post

ImpAct *bottom line*

⇒ ***Take time to work out what you want to do, get the right people, and do it.***

Figure: Prescribing costs in Northgate Medical Centre compared with Health Authority and national equivalent practices



THE DEVELOPING ROLE OF THERAPY ASSISTANTS

I***s progress being maintained on improving amputee rehabilitation at Bradford Hospital?***

In the first issue of ***ImpAct*** (May 1999) we reported on an initiative to explore a new role for therapy assistants at Bradford Hospitals. The aim was to improve rehabilitation services for patients needing lower limb amputation. Given the acknowledged problems of maintaining innovations in the longer term we thought we'd revisit the work to see if progress was being maintained.

Is progress being maintained?

The key achievements of shorter length of stay and the amount of time spent in rehabilitation are being maintained. Several other important benefits have become evident as the initiative has developed. These concern relationships with patients and links with other agencies. Many of these benefits reflect the presence of the therapy assistants in the unit throughout their working day. This on-going contact with patients and carers means that they can develop a unique rapport. Duties of other staff (e.g. doctors, nurses and physiotherapists) mean that they may be away from the ward, or spend less time in direct contact with patients.

The therapy assistants thus provide a valuable channel for information from clinical staff to the patients and from patients to clinical staff. They have space and time to undertake urgent tasks when other people are busy or away from the unit. They can focus on the needs of patients and free qualified therapists to deliver other services. This continuity has helped to improve the focus on the needs of patients. Another important consequence has been improved links with Social Services and the Benefits Agency. The therapy assistants are able to ensure that information is passed on to the relevant discipline to facilitate early discharge.

What problems have arisen?

The appointment of therapy assistants has effectively proved to be a new way in to the NHS. There is little stability in the therapy assistant group. The three full time posts have been changed to two full time and two part-time posts to help respond to the level of turnover. Experience has shown that those appointed soon become ambitious for advancement in the NHS. There is a continuing turnover as those appointed move on to other roles (for example to start training in physiotherapy or nursing).

A new (ongoing) process to recruit and train therapy assistants has been developed by the hospital. This is partly to replace those who move on but also to fill other new posts as the role of therapy assistant has been extended in the hospital (see below).The appointment process provides briefing about what is involved (very important because the aim is to recruit people without clinical experience. Many don't know what to expect). It also ensures that those appointed are allocated to the most appropriate department in the hospital. All therapy assistants have a detailed two-week induction period.

The future

A number of factors have conspired to change the nature of the initiative in the amputee unit. The continuing high level turnover of other staff (doctors and nurses) is significant. Induction training has to make sure that new staff are clear about the role of therapy assistants. It has to overcome rigid traditional views of roles in the face of varying needs of individuals in a situation of little stability.

The initiative created a real buzz when it was first launched in 1996. Perhaps inevitably as the new becomes part of the routine service the buzz is no longer there. Some regret this, but there is a strong commitment to keep the process going. The new role is a real success.

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IMPROVING STROKE SERVICES

Therapy assistants contribute to the successful development of a stroke unit.

Why was the initiative launched?

Therapy and medical staff had highlighted the need for a stroke unit in Bradford Hospitals Trust for several years. Research evidence demonstrated the benefits of a coordinated approach. It was difficult providing effective rehabilitation for patients with stroke illness across some 15 wards on two sites. Many patients seemed to spend much of their day doing nothing. In 1997 the opportunity to make progress arose when senior managers agreed that the introduction of a Stroke Unit should be a top priority. This allowed management time to be devoted to the task, but the caveat was that it had to be achieved within existing resources.

How was the work taken forward?

Multi-disciplinary steering and operational groups were formed early in 1997 to develop and implement proposals. They were asked to work in a time frame of less than six months. The plan was to have the unit operational by Oc-

tober 1997. Jackie Hansford, a nurse manager at the Trust, led the work. Operational policy was developed in the light of research evidence with the aim of offering effective rehabilitation and improving lengths of stay through a coordinated approach.

A role for therapy assistants

Therapy assistants had been shown to improve patients' experience of rehabilitation and to shorten length of stay on the amputee unit in vascular elective orthopedic wards in the Trust (***ImpAct*** May 1999: issue 1). A team of occupational therapy and physiotherapy managers led by Val Steele, Director of Rehabilitation, adapted the model to provide support staff to the qualified therapy team in the Stroke Unit. The assistants would be trained to deliver rehabilitation packages planned and monitored by the qualified therapists, including speech and language therapists. The team decided that the therapy assistants would not be trained in nursing duties to ensure that the emphasis on rehabilitation was maintained. Experience had shown that caring/nursing demands tended to detract from rehabilitative activities when there was pressures on wards.

A key appointment in the stroke unit was Mary Hudson as lead therapist. A senior sister was also appointed. The lead therapist has a key leadership role with the therapy team and the rest of the multi-disciplinary team in achieving and maintaining a rehabilitation ethos in the ward. The lead therapist, therapists and assistants are based on the ward.

Filling new posts

Because the development work had to be contained within existing resources additional funding for the new posts was not available. This meant that short-term appointments had to be made. There was some concern that recruitment of therapy assistants might be difficult because of the short-term nature of the posts and the salary scale. These fears were unfounded; in the event, there was a big response to local advertisements.

What has been the impact of therapy assistants on the stroke unit?

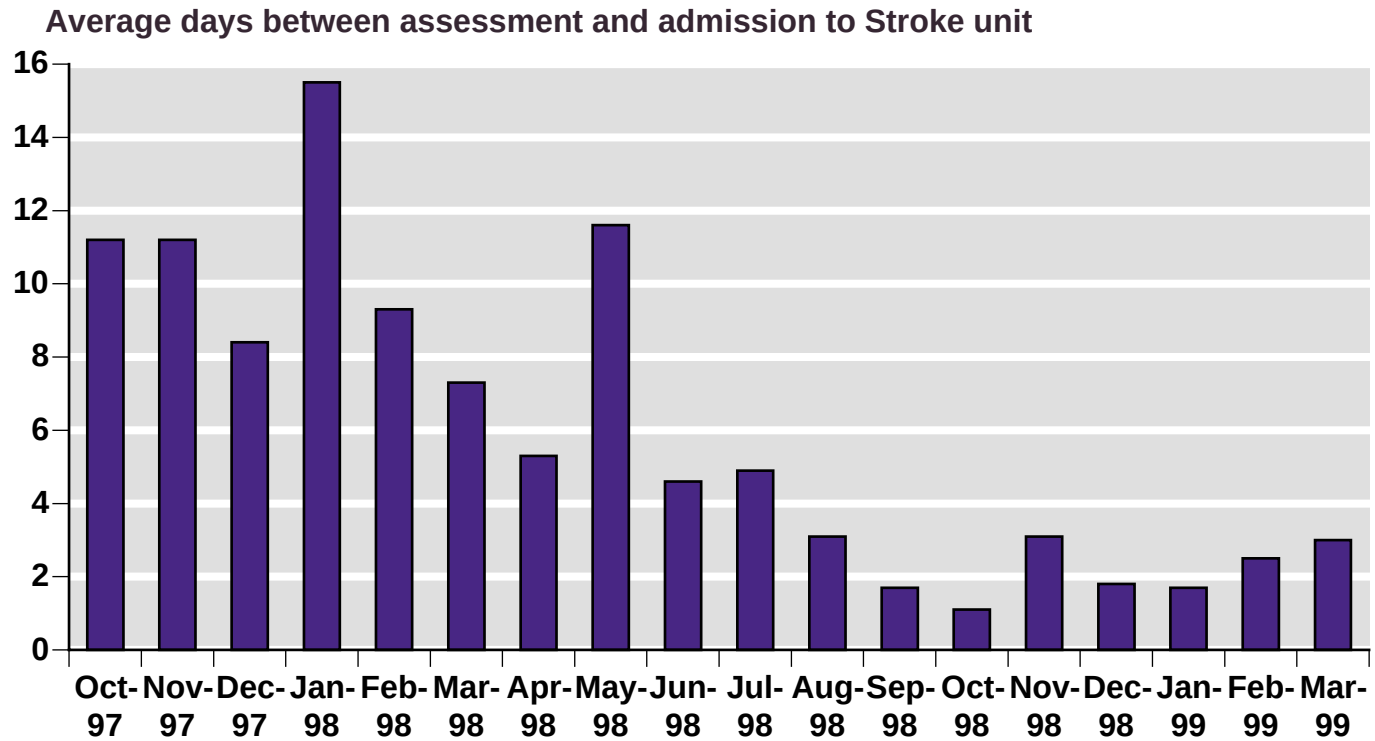
Six part-time assistants were appointed in 1997 (three wte), initially on six month contracts. The appointees had a range of backgrounds, including one person taking a gap year before starting medical training. Another two have completed the necessary A levels to allow them to be accepted onto a physiotherapy degree course.

From the start the therapy assistants worked weekdays with the therapists. Later as they achieved identified competency levels; they covered the seven-day week delivering therapy programmes planned by the qualified therapists to meet identified goals, reviewed weekly by the team. Support and training for the assistants is organised by the lead therapist. Following the success of the initiative recurrent funding for the posts is now secure.

The contribution of therapy assistants

There was some scepticism initially from other disciplines about the contribution the assistants could make, but this evaporated as the benefits began to be realised. The Stroke Unit team has introduced shared patient records, multi-disciplinary reviews and goal setting (with the patients) on a weekly basis and regular in-service training for the staff on the Unit. Assistants have been involved and appear to make

Figure: Impact of changes in Bradford on the time taken to transfer patients to the Stroke Unit from other parts of the hospital



an impact on the rehabilitation package, although this is difficult to quantify.

Over the first 18 months significant improvement was made to reduce the time taken to transfer patients to the Stroke Unit from other parts of the hospital (Figure 1). It is now being maintained at about two to three days. The length of stay in the Unit has stabilised at about 30 days. Overall performance continues to be well below the national target (57 days overall). Local audits have shown increased rehabilitative activity. The presence of the assistants has ensured that qualified therapists can focus their attention on complex work that cannot be undertaken by support staff.

The work in Bradford has shown that some of the national shortfall in qualified therapists can be overcome by the judicious use of well-trained and supervised therapy assistants. Working across professional boundaries they help ensure that patients receive an integrated rehabilitation package. The unit compared positively with other centres in a National Sentinel Stroke Audit. The Stroke Unit was commended by the Audit Commission as a centre of good practice in "The way to go home: rehabilitation and remedial services for older people", Audit Commission, 2000.

What has been learnt about the employment of therapy assistants?

The Stroke Unit in Bradford has demonstrated that:

1 Therapy assistants can be important channels of communication with patients and families. It is important that they have the opportunity to pass on the information to therapists and other members of the team, for example at the regular goal setting meetings.

2 The views of patients and their families must be considered. Initially, the therapy assistants worked seven days a week for full days but patients made it clear that they did not want (and many could not cope with) early evening activity and they valued a quiet Sunday. The assistants now work from 8.15 am to 4.15 p.m.

3 Other members of the team need training to understand the role of assistants and, indeed the role of therapists. Most new members of the multi-disciplinary team will not have experience of working with therapy assistants

4 The assistants should help out nursing colleagues when the unit is unusually busy. Give and take ensures harmonious working, but the therapeutic role must be protected for the benefit of patients.

5 There is a tendency for caring activities to predominate in busy ward areas, even if they have a rehabilitation role. A focus on therapeutic activity ensures that patients can benefit from consistent rehabilitation even when the unit is very busy and/or short of nursing staff.

6 A revised approach for carers' groups may be needed. Therapy assistants provide a good point of contact with patients and carers and can be valuable as 'information providers'. Support for the Carers Group at Bradford started to dwindle because patients and carers were receiving adequate information.

7 There are opportunities to use the posts as an entry into health related training. Most of those appointed initially have moved to other jobs in the NHS and have benefited from their experience. They are not highly paid posts and this probably impacts on the length of time that people stay. Nevertheless, the posts can provide a springboard to professional training.

Looking to the future

A pilot outreach service to support patients in the early transition stage after hospital in-patient discharge is being planned largely using experienced therapy assistants. It will be implemented subject to the availability of the necessary resource.

Tips for Success

√ Take opportunities as they arise: be ready to take risks
√ Make sure that the work is led by a respected local clinician.
√ Be clear about the competencies required to work effectively with individual client groups
√ Provide structured introductory training, on-going monitoring, support and development for therapy assistants.
√ Don't sit back and relax when you fill posts: have contingency plans to cope with staff turnover. They may soon want to move on!

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The following material is available:

Training programme for Therapy Assistants in Stroke Units

ImpAct *bottom line*

⇒ ***Non-clinical recruits can be trained to provide an important components of care and ensure rehabilitation proceed quickly.***

Bandolier/ImpAct Internet site

The ***Bandolier/Impact*** management site on the Internet now has over 170 stories of interest to people who want to make their healthcare system better. The policy is to add more material on a continuous basis. This month there are a number of new articles. Four examples follow:

Waste in the NHS

This is the title of a Praefectus' seminar for postgraduate students of Balliol College in Holywell Manor in 1999. The updated lecture is being posted on the management site. It is a series of examples of how the NHS wastes its resources, and how it could do better with the resources it has. This is not a criticism of the good people who work in the NHS and who make it work, but a call for more support for them.

Cost-effectiveness of antiseptic impregnated catheters

A US study in JAMA shows that antiseptic impregnated central venous catheters save an average of $196 per catheter in healthcare costs in patients at high risk of catheter related bloodstream infections, like those in intensive care. It is based on high quality information from a meta-analysis of randomised trials. Although it has a US context, it is likely that savings would occur in any healthcare model.

Cost burden of latex allergy in healthcare systems

These results relate to Georgia, USA, which has very conservative worker compensation benefits. Countries with more generous benefits packages would make the use of latex-safe gloves more cost-effective. This article demonstrates how any institution could approach the issue of latex allergy for itself. That might be a very sensible thing to do. The evidence about latex and its health consequences is substantial. Workers injured through latex contact when there are safe alternatives with a cost argument that is balanced might have a good case for significant damages for negligence against management. That would send the costs of not having a latex-safe policy even higher.

Economic analysis of Ottawa knee rule

Bandolier 49 carried an article about the way in which the Ottawa knee rule was determined and tested. The clinical decision rule helps determine whether an X-ray is necessary in acute knee injuries. It examined five simple clinical findings and had a sensitivity of 100% for detecting important fractures. Use of the rule reduced use of X-rays by 26% and average waiting time by 33 minutes per patient. An economic evaluation demonstrates substantial cost reductions of about $33 (£20) per patient in a north American setting.

Beacon Services

The NHS Beacon programme was launched in 1999 to identify services that make significant contributions to modernising the NHS. The programme was designed to help people in other organisations learn how to mirror these experiences. NHS Executive Regional Offices provide advice on dissemination and link Beacons into regional plans, as well as with specialist learning centres. Beacons are also linked directly with national initiatives and programmes, and feature in guidance like National Service Frameworks.

In the first year of the programme 290 Beacon services in six broad areas were announced. ***ImpAct*** has included several case studies of these Beacons. The second year of the programme, announced on 15 September 2000, includes 68 new Beacons for 2000/2001 in eight broad areas (Table). These include five related to personality disorder in a new joint programme with the Home Office.

A handbook identifies Beacon services and the learning they have to offer, about open days when people can visit Beacons, and other learning opportunities. Copies of the handbook are circulated widely within the service or can also be ordered from Status (below); an on-line version is available on the Beacon web-site at www.nhs.uk/beacons.

NHS Beacon Programme

Contact	Carolyn Johnson, at Status
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